City of Marietta/BLW

CLAIM FORM
REQUEST FOR REIMBURSEMENT

PERSONNEL USE ONLY
DATE RECEIVED_____
☐ APPROVED ☐ INTEROFFICE
☐ DENIED ☐ MAIL
☐ PENDING ☐ HAND DELIVERED

PART 1 – EMPLOYEE INFORMATION (PLEASE PRINT)

EMPLOYEE'S NAME_____ EMPLOYEE'S NO._____

EMPLOYER: City of Marietta DEPT. NUMBER_____ WORK TELEPHONE#_____

PART 2 – FOR DEPENDENT DAY CARE EXPENSE CLAIMS

NAME OF DEPENDENTS	PERIOD CLAIMED FROM	TO	NAME AND ADDRESS OF PROVIDER OF SERVICE	AMOUNT INCURRED
*TOTAL DEPENDENT DAY CARE EXPENSES CLAIMED				

*NOTE: THE TOTAL AMOUNT CLAIMED UNDER THE DEPENDENT DAY CARE PLAN FOR ANY COVERAGE PERIOD MUST NOT EXCEED THE LESSER OF YOUR EARNED INCOME FOR THE PLAN YEAR OR THE EARNED INCOME OF YOUR SPOUSE. (IF YOUR SPOUSE IS EITHER A FULL TIME STUDENT OR IS INCAPABLE OF SELF-CARE, THEN HE OR SHE IS DEEMED TO HAVE MONTHLY EARNINGS OF $200 IF THERE IS ONE (1) CHILD OR DEPENDENT, AND $400 IF THERE ARE TWO (2) OR MORE. NO PAYMENT MAY BE MADE UNDER THE PLAN IF THE SERVICE PROVIDER IS YOUR DEPENDENT FOR FEDERAL INCOME TAX PURPOSES, OR IS YOUR CHILD OR STEPCHILD AND IS UNDER AGE 19.

PART 3 – FOR UNREIMBURSED MEDICAL EXPENSE CLAIMS

DATE EXPENSE INCURRED	NAME OF SERVICE PROVIDER	EXPENSE DESCRIPTION	PERSON FOR WHOM EXPENSE INCURRED	AMOUNT WHICH YOU ARE RESPONSIBLE
TOTAL MEDICAL CARE EXPENSES CLAIMED				

PART 4 – EMPLOYEE'S SIGNATURE (REQUIRED)

THE EXPENSES CLAIMED ABOVE ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF. I AGREE THAT THE PLAN WILL HAVE THE RIGHT TO RECOVER ANY REIMBURSEMENT MADE TO ME FOR ANY EXPENSE FOUND TO BE FALSE OR OTHERWISE INELIGIBLE FOR REIMBURSEMENT UNDER IRS GUIDELINES AND THAT I MAY BE LIABLE FOR PAYMENT OF ALL RELATED TAXES INCLUDING FEDERAL AND STATE INCOME TAX ON AMOUNTS PAID FOR THE PLAN, WHICH RELATE TO SUCH EXPENSE. I CERTIFY THAT THE EXPENSES CLAIMED HAVE NOT NOR WILL BE REIMBURSED FROM ANY OTHER SOURCE. I UNDERSTAND THAT ANY EXPENSE REIMBURSED UNDER THIS PLAN MAY NOT BE CLAIMED AS DEDUCTIBLE EXPENSE ON MY FEDERAL OR STATE INCOME TAX RETURN.

X_____

EMPLOYEE'S SIGNATURE **DATE**

READ CAREFULLY
CLAIM FILING INSTRUCTIONS

WHO MAY FILE A CLAIM FORM

. Only employees participating in the Plan may file a reimbursement claim form.
. Employees may file a claim form during the Plan Year and for a certain period after the Plan Year ends as described in the Summary Plan Description.
. Terminated employees may file a claim form for a certain period after the date of termination as described in the Summary Plan Description.

WHAT EXPENSES MAY BE CLAIMED

. Only expenses actually incurred during the Plan Year may be claimed for reimbursement. Each year is treated separately. Expenses may not be carried forward from one Plan Year to the next.
. Allowable expenses are generally the same as those allowed for tax purposes.
. Only expenses not paid or reimbursed by insurance or any other source can be claimed. Additionally, expenses reimbursed under this Plan may not be claimed as a deductible expense on the employee's federal or state income tax return.

COMPLETION OF THE CLAIM FORM

. Complete all information on the reverse side of this claim form, for each amount claimed for reimbursement.
. Make sure the claim does not include items for more than one Plan Year.
. Make sure the claim does not include expenses incurred prior to the beginning of the applicable Plan Year or your date of entry into the Plan, whichever is later.
. **You must sign and date the claim form.**

TO CLAIM MEDICAL EXPENSES

Have you submitted proper evidence of the claimed expense? Proper evidence of your expense must be from an independent third party(such as a copy of the Explanation of Benefits from your insurance company or an itemized statement from the provider). Charge receipts, cash register receipts, cancelled checks or statements indicating payments on an account **are not acceptable** documentation. Proper evidence of an expense must include the provider's name, address, the nature of the expense, the date the service was provided, the name of the employee, spouse or dependent for whom the expense was incurred, and the dollar amount of the expense. **Remember.....**
FEDERAL REGULATIONS PROHIBIT THE Plan from reimbursing any expense that has been paid or will be paid by insurance or reimbursed through any other source. If the expense is a covered expense under any insurance policy, it should first be filed with the insurance carrier prior to submission for reimbursement under this reimbursement Plan.

TO CLAIM DEPENDENT DAY CARE EXPENSES

Have you completed all requested information under the Dependent Day Care Expense portion on the reverse side of this Claim Form? Include the name of each dependent for whom the expense was incurred, the date of service was provided, the name and address of the sitter, day care center or nursery, and the amount of the expense. You do not need to attach a separate receipt if you provide all the requested information and sign the Claim Form.
YOU MUST PROVIDE A COMPLETED IRS FORM W-10 FOR EACH DEPENDENT CARE PROVIDER YOU USE DURING THE PLAN YEAR.

MAIL YOUR COMPLETED CLAIM FORM TO: CITY OF MARIETTA, PAYROLL DEPT.
P. O. BOX 609, MARIETTA, GA. 30061

FOR ACCOUNT INQUIRIES CALL 770-794-5573 OR FAX 770-794-5565